

Proposed Rule
LSA Document #12-451

DIGEST

Adds [405 IAC 5-2-7.1](#) to add the definition for curative care services. Amends [405 IAC 5-34-5](#) to add face-to-face encounter requirements for continued hospice eligibility. Amends [405 IAC 5-34-6](#) to allow Medicaid recipients less than twenty-one (21) years of age to receive curative care services concurrently with hospice services. Amends [405 IAC 5-34-7](#) to add plan of care requirements for Medicaid recipients less than twenty-one (21) years of age receiving curative services concurrently with hospice services. Effective 30 days after filing with the Publisher.

[IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses](#)

[405 IAC 5-2-7.1](#); [405 IAC 5-34-5](#); [405 IAC 5-34-6](#); [405 IAC 5-34-7](#)

SECTION 1. [405 IAC 5-2-7.1](#) IS ADDED TO READ AS FOLLOWS:

[405 IAC 5-2-7.1](#) "Curative care services" defined

Authority: [IC 12-8-6.5-5](#); [IC 12-15](#)

Affected: [IC 12-15](#)

Sec. 7.1. "Curative care services" means services that are related to the treatment of the medical condition for which diagnosis of terminal illness has been made.

(Office of the Secretary of Family and Social Services; [405 IAC 5-2-7.1](#))

SECTION 2. [405 IAC 5-34-5](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 5-34-5](#) Physician certification

Authority: [IC 12-8-6.5-5](#); [IC 12-15](#)

Affected: [IC 12-15](#)

Sec. 5. (a) In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing that the individual is terminally ill and expected to die from that illness within six (6) months. For a dually-eligible Medicaid/Medicare recipient, the hospice provider must comply with Medicare physician certification requirements, but the provider is not required to complete the Medicaid physician certification form or to submit the physician certification to the office. For a Medicaid-only hospice recipient, the Medicaid physician certification form must be completed and submitted to office as set out in this section.

(b) As required by federal regulations, the certification in subsection (a) must:

(1) be completed for the first period of ninety (90) days by **the**:

(A) ~~the~~ medical director of the hospice program or the physician member of the hospice interdisciplinary group; and

(B) ~~the~~ recipient's attending physician if the recipient has an attending physician;

(2) be completed by one (1) of the physicians listed in subdivision (1)(A) for the second and subsequent periods;

(3) be signed and dated;

(4) identify the diagnosis that prompted the individual to elect hospice services;

(5) include a statement that the prognosis for life expectancy is six (6) months or less; and

(6) be submitted to the office or its designee within the time frames in subsection (c).

(c) The Medicaid physician certification must be submitted for the first period within ten (10) business days of the effective date of the Medicaid-only recipient's election. For the second and subsequent periods, the Medicaid

physician certification must be submitted within ten (10) business days of the beginning of the benefit period.

(d) For the Medicaid-only hospice recipient, the Medicaid physician certification form must be included in the recipient's medical chart in the hospice agency and the recipient's medical chart in the nursing facility.

(e) Prior to the beginning of the recipient's third benefit period or one hundred eightieth day of hospice service and prior to each subsequent benefit period, a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with the recipient to gather clinical findings to determine continued eligibility for hospice care and must attest in writing that such a visit took place. The face-to-face encounter must occur not more than thirty (30) calendar days prior to:

- (1) the third benefit period recertification; and**
- (2) every subsequent recertification thereafter.**

(Office of the Secretary of Family and Social Services; [405 IAC 5-34-5](#); filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#))

SECTION 3. [405 IAC 5-34-6](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 5-34-6](#) Election of hospice services

Authority: [IC 12-8-6.5-5](#); [IC 12-15](#)

Affected: [IC 12-15](#)

Sec. 6. (a) In order to receive hospice services, a recipient must elect hospice services by filing an election statement with the hospice provider on forms specified by the office.

(b) **For recipients at least twenty-one (21) years of age**, election of the hospice benefit requires the recipient to waive Medicaid coverage for the following services:

- (1) Other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness.
- (2) Services provided by another provider ~~which that~~ are equivalent to the care provided by the elected hospice provider.
- (3) Hospice services other than those provided by the elected hospice provider or its contractors.

(c) For recipients less than twenty-one (21) years of age who elect the hospice benefit, the recipient may receive concurrent curative care services in conjunction with hospice services for the terminal illness. This allows the recipient or the recipient's representative to elect the hospice benefit, without forgoing any curative service the recipient is entitled to under Medicaid for treatment of the terminal illness.

~~(e)~~ **(d)** The recipient or recipient's representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date of election.

~~(d)~~ **(e)** For Medicaid-only hospice recipient, the Medicaid election form must be submitted to the office or its designee along with the Medicaid physician's certification required by section 5 of this rule when hospice services are initiated. It is not necessary to submit the Medicaid election form for the second and subsequent benefit periods unless the recipient has revoked the election and wishes to reelect hospice care.

~~(e)~~ **(f)** For the dually-eligible Medicare/Medicaid hospice recipient residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the recipient's signature must be submitted with the Medicaid hospice authorization form for dually-eligible Medicare/Medicaid nursing facility residents. It is not necessary to submit the Medicare election form for the second and subsequent benefit periods unless the recipient has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

~~(f)~~ **(g)** In the event that a recipient or the recipient's representative wishes to revoke the election of hospice services, the following apply:

- (1) The individual must file a hospice revocation statement on a form approved by the office. The form includes a signed statement that the individual revokes the election of Medicaid hospice services for the remaining days in the benefit period. The form must specify the date that the revocation is to be effective, if later than the date the form is signed by the individual or representative. An individual or representative may not designate an effective date earlier than the date that the revocation is made.
- (2) A recipient may elect to receive hospice care intermittently rather than consecutively over the benefit periods.
- (3) If a recipient revokes hospice services during any benefit period, time remaining on that benefit period is forfeited.
- (4) The revocation form must be completed for Medicaid-only hospice recipients as well as dually-eligible Medicare/Medicaid hospice recipients residing in nursing facilities. The hospice provider must submit this form to the office or its designee.
- (5) The Medicaid hospice revocation form must be included in the recipient's medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, the Medicaid hospice revocation form must be included in the recipient's nursing facility medical chart as well.

~~(g)~~ **(h)** A recipient or a recipient's representative may change hospice providers once during any benefit period. This change does not constitute a revocation of services. The following apply when a recipient changes hospice providers:

- (1) To change the designation of hospice programs, the individual or the individual's representative must complete the Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form or other form designated by the office for this purpose. This form is required for the Medicaid-only hospice recipient and the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility. The original provider must submit this form to the office or its designee.
- (2) The Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form, or other form designated by the office for this purpose, must be included in the recipient's medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, this form must be included in the recipient's nursing facility chart. This documentation requirement is for the Medicaid-only hospice member as well as the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility.

(Office of the Secretary of Family and Social Services; [405 IAC 5-34-6](#); filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3639; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#))

SECTION 4. [405 IAC 5-34-7](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 5-34-7](#) Plan of care

Authority: [IC 12-8-6.5-5](#); [IC 12-15](#)

Affected: [IC 12-15](#)

Sec. 7. (a) When an eligible recipient elects to receive services from a certified hospice provider, the provider shall develop a plan of care. For the Medicaid-only hospice recipients, the provider must submit the Medicaid plan of care form to the office or the office's contractor with the Medicaid physician certification and the Medicaid election statement. **For recipients less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the providers rendering those services must submit an updated plan of care, including delineation of hospice and curative care services, to the office or the office's contractor.**

(b) In developing the plan of care, the provider must comply with the following procedures:

- (1) The interdisciplinary team member who drafts the plan must confer with at least one (1) other member of the interdisciplinary team.
- (2) One (1) of the conferees must be a physician or nurse, and all other team members must review the plan of care.
- (3) All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(4) For the Medicaid-only hospice recipient, the Medicaid hospice plan of care must be included in the recipient's medical chart at the hospice agency. If the Medicaid-only recipient resides in a nursing facility, the Medicaid plan of care must also be included in the recipient's nursing facility medical chart.

(5) For the dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility, a coordinated plan of care prepared and agreed upon by the hospice and nursing facility must be included in the recipient's nursing facility medical chart.

(6) For recipients less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the Medicaid plan of care must include the information identified previously in this section, and a coordinated plan of care must be prepared and agreed upon by the hospice interdisciplinary team and the provider or providers rendering the curative care services. The plan of care must include the following:

(A) An assessment of the recipient's needs.

(B) The curative care and hospice services the recipient is receiving along with the scope and frequency of these services and the manner in which the services and assessments are coordinated.

(C) The criteria for terminating curative care services.

The plan of care and advanced directive must be included in the recipient's medical charts of both the hospice and curative care providers.

(Office of the Secretary of Family and Social Services; [405 IAC 5-34-7](#); filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3640; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#))

[Notice of Public Hearing](#)

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